The role of DIALECTICAL BEHAVIOUR THERAPY (DBT) & the use of dialectical strategies in the treatment of eating disorders

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What we'll cover

- Various applications of DBT to treatment of EDs
- Research studies
- Full and partial DBT
- Use of DBT strategies in treatment of EDs

What is DBT

An intensive psychological treatment for people with BDP who self harm

6-12* months of

- weekly skills group,
- individual therapy,
- therapist consultation team meeting, and
- ‘24-hour’ telephone coaching.

*6 months may be sufficient for some patients

Stanley, Brodsky, Nelson & Dulit. Brief Dialectical Behavior Therapy (DBT-B) for Suicidal Behavior and Non-Suicidal Self Injury Archives of Suicide Research, Volume 11, Issue 4 November 2007 , pages 337 - 341 n=20

How DBT can contribute to the treatment of EDs

1 To treat patients with EDs BPD and DSH

2 To inform the treatment of EDs

- Dialectics
- Other DBT strategies esp. commitment
- Telephone coaching

3 To treat patients with EDs who have difficulty regulating their emotions (Wagner et al 2007) i.e. ‘on the borderline spectrum’ (partial DBT).

ED & PD

High comorbidity between EDs & BPD. These patients often

- substitute other maladaptive coping strategies if treat ED in isolation (unwise to do so).
- respond less well to conventional ED treatments esp. admission.

Patients with persistent EDs high likelihood of PD but not nec BPD. However those with BPD may place high demands on services (high overt distress & more likely to demand help).

Despite the significant overlap between the two disorders, there is a dearth of empirically supported treatments for this population.

Papers on DBT & EDs

1. Treatment proposals 1999/ 2003 plus
2. Research studies

- BED
- BN
- BPD & ED

(1 qual study & trial underway for AN)

1. Wiser and Telch (1999)

modification to DBT for bulimics proposed a 10-session program and includes clinician guidelines and client worksheets for each session.

1. L Wisniewski, and E Kelly The application of DBT to the treatment of eating disorders Cognitive and Behavioral Practice **Volume 10, Issue 2,** Spring 2003, Pages 131-138

Propose that appropriately trained therapists may use the standard DBT model with some adjustments for an eating disorder diagnosis. These adjustments are both theoretical and practical and include broadening the biosocial theory, developing eating disorder-specific dialectics, highlighting eating disorder behaviors in the treatment targets, expanding the diary card, and adding a nutrition skills module.

1. Wisniewski, L, Ben-Porath, D D. Telephone skill-coaching with eating-disordered clients: clinical guidelines using a DBT framework European Eating Disorders Review, Volume 13, Number 5, Sept 2005 , pp. 344-350(7)

Authors propose that a DBT-based telephone skill-coaching model can be a useful adjunct to the treatment of eating disorders. The current paper describes the standard telephone skill-coaching model, the adaptations necessary for its use with eating disorder clients and a protocol that may be used with this population.

Discussion

- Benefits and issues in providing telephone coaching in EDs

DBT for AN

Interviews with 4 recovering from AN

Co-participants described the experience of using restrictive behavior to "numb" feelings. Ultimately the co-participants‘ experiences reveal that it was challenging yet possible to replace restrictive behavior with dialectical behavior therapy skills. At the end of their recovery process, all of the women experienced a newfound ability to assert themselves, to accept their emotions, and to tolerate distress. They also experienced a shift in how they viewed themselves and their world. They became more accepting of themselves and their world became more full of possibility and meaning.

DBT in the treatment of anorexia nervosa: What is the anorexic's experience of replacing restrictive behavior with DBT skills? Dissertation Abstracts International: Section B: The Sciences and Engineering, 2009,vol./is. 69/10-B(6412), 0419-4217 (2009) Hailey B

DBT for emotional over-control

New adapted form of DBT for emotional restriction developed by Tom Lynch *Radical openness*

Skills acquisition and generalisation are targeted at:

• reducing behavioural over-control, rigidity and emotional constriction

• increasing flexibility, openness to new experiences and encouraging expression of emotions.

Good feedback from patients with restrictive AN and possible *other* PD features e.g. OCPD or avoidant UK trial underway

Haldon Unit Exeter

DBT studies in ED populations

Strong evidence base for DBT for people with BPD and DSH or sub misuse.

Small growing evidence base for EDs esp for BED

BED

CF Telch, WS Agras, MM Linehan - Group DBT for binge-eating disorder: A preliminary, uncontrolled trial Behavior Therapy Volume 31, Issue 3, 2000, Pages 569-582

Eleven women with BED

uncontrolled trial

3- and 6-month follow-up.

There were no dropouts from treatment

82% of the women were no longer binge eating by treatment end. Improvement in emotion regulation was also evidenced post-treatment. The improvement in binge eating was maintained during follow-up.

Telch, Christy F.; Agras, W. Stewart; Linehan, Marsha M. DBT for binge eating disorder Journal of Consulting and Clinical Psychology. Vol 69(6), Dec 2001, 1061-1065.

Women with BED (**N=44**) were randomly assigned to group DBT or to a wait-list control condition.

Treated women evidenced **significant improvement on measures of binge eating and eating pathology compared with controls, and 89% of the women receiving DBT had stopped binge eating by the end of treatment. Abstinence rates were reduced to 56% at the 6-month follow-up.**

D Safer et al. Outcome From a Randomized Controlled Trial of Group Therapy for Binge Eating Disorder: Comparing DBT Adapted for Binge Eating to an Active Comparison Group Therapy Behavior Therapy **Volume 41, Issue 1, 2010, Pages 106-120**

Men and women **(*n* = 101)** with BED randomly assigned to 20 group sessions of DBT-BED or ACGT.

Although both DBT-BED and ACGT reduced binge eating, DBT-BED showed significantly fewer dropouts and greater initial efficacy (e.g., at post-treatment) than ACGT. Lack of differential findings over follow-up suggests that the hypothesized specific effects of DBT-BED do not show long-term impact beyond those attributable to nonspecific therapeutic factors. Secondary outcome measures revealed no sustained impact on emotion regulation.

BED

- 2000 uncontrolled trial n=11
- 2001 RCT n=44
- RCT 2010 n=101

no evidence of sustained impact on emotion regulation.

BN

- 2001 RCT n=31
- 2009 RCT n=26/32

Debra L. Safer, Christy F. Telch, and W. Stewart Agras
DBT for Bulimia Nervosa. Am J Psychiatry 158:632-634, April 2001

Thirty-one women (averaging at least one binge/purge episode per week) were randomly assigned to 20 weeks of DBT or 20 weeks of a waiting-list comparison condition.

An intent-to-treat analysis showed **highly significant decreases in binge/purge behavior** with DBT compared to the waiting-list condition.

No significant group differences were found on any of the secondary measures.

Hill, Diana Marie **Appetite-focused dialectical behavior therapy for the treatment of binge eating with purging: A randomized controlled trial.** Dissertation Abstracts International: Section B: The Sciences and Engineering, 2009,vol./is. 69/7-B(4424), 0419-4217

The goals of this modified treatment, Appetite Focused DBT (DBT-AF), are to increase women's awareness of both their emotional and appetite signals and to teach them to use appetite awareness skills and adaptive emotion regulation to replace maladaptive eating behaviors.

26/32 women with binge and purge episodes of at least once per week were randomly assigned to receive **12 sessions of DBT-AF** (n = 18) or to a 6-week delayed treatment control group n = 14). At 6-weeks, the DBT-AF group reported significantly greater reductions in BN symptoms compared to delayed treatment. Participants reported significant reductions in symptoms of BN, as well as significant increases in appetite awareness and effective emotion regulation.

Early improvement in restraint and appetite awareness was the central mechanisms of DBT-AF in reducing purge episodes.

Treatment attrition was low (15.4%), and DBT-AF was rated as highly acceptable by both therapists and clients.

Comorbid BPD & ED

- Leicester study 2003
- 2008 n=13
- 2008 n=101
- 2010 n=33
- 2010 inpatients n=44

Palmer RL et al (2003). A DBT program for people with an eating disorder and borderline personality disorder description and outcome. IJED, vol. 33, no.3, p. 281-6

- Evaluated a full DBT (DBT) program for people with comorbid eating disorder and borderline personality disorder. The program included a novel skills training module written especially for eating-disordered patients.
  The program was run for 18 months.
- Days in hospital and major acts of self-harm were counted for the 18 months before and after DBT.
- There were no dropouts from the program. **Most patients were neither eating disordered nor self-harming at follow-up.**

E Y Chen, L Matthews, C Allen, J R Kuo, M M Linehan.
DBT for clients with binge-eating disorder or bulimia nervosa and borderline personality disorder. Int J Eat Disord 2008 Volume 41 Issue 6, Pages 505 - 512

N=13. 8 women with binge-eating disorder (BED) (5) or bulimia nervosa (BN) (3) *and* Borderline Personality Disorder (BPD).

From pre- to post-treatment, effect sizes for objective binge eating, total EDE scores and global adjustment were large and for number of non-eating disorder axis I disorders and for suicidal behavior and self-injury were medium.

From pre- to 6-months follow-up, effect sizes were large for all these outcomes.

Harned MS; et al **Treating co-occurring Axis I disorders in recurrently suicidal women with borderline personality disorder: a 2-year randomized trial of dialectical behavior therapy versus community treatment by experts.** Journal of Consulting & Clinical Psychology, Dec 2008, vol./is. 76/6, 1068-75.

reprinted

Harned, Melanie S; Chapman, Alexander L; Treating co-occurring Axis I disorders in recurrently suicidal women with borderline personality disorder: A 2-year randomized trial of dialectical behavior therapy versus community treatment by experts. Personality Disorders: Theory, Research, and Treatment, August 2009, vol./is. S/1(35-45)

This study evaluated whether DBT was more efficacious than treatment by nonbehavioral psychotherapy experts in reducing co-occurring Axis I disorders among suicidal individuals with BPD. Women with BPD and recent and repeated suicidal and/or self-injurious behavior (**n = 101)** were randomly assigned to 1 year of DBT or community treatment by experts (CTBE), plus 1 year of follow-up assessment.

DBT and CTBE did not significantly differ in the reduction of anxiety disorders, eating disorders, or major depressive disorder.

Ben-Porath, Denise D; Wisniewski, Lucene; Warren, Mark **Differential treatment response for eating disordered patients with and without a comorbid borderline personality diagnosis using a dialectical behavior therapy (DBT)-informed approach.** Eating Disorders: The Journal of Treatment & Prevention, May 2009, vol./is.17/3(225-241),

Results indicated that while a comorbid diagnosis of BPD did not impact eating disorder treatment outcomes, those comorbidly diagnosed did present overall with higher levels of general distress and psychological disturbance.

With respect to affect regulation, results indicated that at the beginning of treatment, eating disordered individuals who carried a comorbid diagnosis of BPD were significantly less able to regulate affect than patients without a comorbid borderline diagnosis However, at the end of treatment there was **no statistically significant difference in affect regulation between the two groups.**

Federici, Anita **Effectiveness of a Dialectical Behavior Therapy skills group for the treatment of suicidal/self-injurious behavior and eating disorder symptoms in patients with borderline personality disorder.** Dissertation Abstracts International: Section B: The Sciences and Engineering, 2010, vol./is. 70/9-B(5817)

- 20-week DBT skills training intervention delivered as an adjunct to non-DBT individual therapy for individuals with comorbid BPD, binge eating and/or purging behaviours, and recurrent suicidal/self-injury **(n = 33)**.
- Participation in the DBT skills group was associated with a significant decrease in the number of suicidal and self-injurious episodes over time. **There were no significant differences on the number of episodes of binge eating or vomiting**. Significant differences were detected on a number of secondary outcomes including ED-related personality characteristics, affect lability, BPD-related symptomatology, and mindfulness.

Kroger, et al Dialectical behaviour therapy and an added cognitive behavioural treatment module for eating disorders in women with borderline personality disorder and anorexia nervosa or bulimia nervosa who failed to respond to previous treatments. An open trial with a 15-month follow-up. J**ournal of Behavior Therapy and Experimental Psychiatry, Dec 2010, vol./is. 41/4(381-388).**

24 women with BPD (9 with comorbid anorexia nervosa [AN] and 15 with bulimia nervosa [BN]), who already had failed to respond to previous eating-disorder related inpatient treatments were consecutively admitted to an adapted **inpatient DBT program**. Assessment points were at pre-treatment, post-treatment, and 15-month follow-up.

At follow-up, the remission rate was 54% for BN, and 33% for AN. Yet 44% of women with AN crossed over to BN and one woman additionally met the criteria of AN. For women with AN, the mean weight was not significantly increased at post-treatment, but had improved at follow-up. For women with BN, the frequency of binge-eating episodes was reduced at post-treatment as well as at follow-up. Self-rated eating-related complaints and general psychopathology, as well as ratings on global psychosocial functioning, were significantly improved at post-treatment and at follow-up.

What about adolescents?

Salbach-Andrae, H et al **Dialectical behavior therapy of anorexia and bulimia nervosa among adolescents: A case series.** Cognitive and Behavioral Practice, November 2008, vol./is. 15/4(415-425), 1077-7229

Case series of adolescents (mean age = 16.5 years) with anorexia nervosa (AN) and bulimia nervosa (BN) who received DBT. **Twelve outpatients with AN and BN took part in 25 weeks of twice weekly therapy consisting of individual therapy and a skills training group**. Family members were involved in the treatment.

Posttreatment, significant improvements in behavioral symptoms of eating disorder and symptoms of psychopathology were identified. The application of DBT adapted for the treatment of AN and BN among adolescents was associated with a decrease in behavioral symptoms of eating disorders and symptoms of general psychopathology. However, randomized controlled studies are required to prove the efficacy of this approach.

Issues when treating people with EDs in full DBT

- Targeting restrictive eating which is more continuous (self - starvation) or absence of skilful behaviour
- Are EDs life-threatening, therapy-interfering or ‘quality of life’-interfering behaviours?
- EDs should be prioritised alongside DSH according to risk (e.g. hypokalemia) but this may not be understood or assessed accurately if DBT delivered by non-ED therapists
- Do you provide DBT and ED treatment simultaneously or sequentially?
- Should a minimum weight be required for participation?

Many patients with EDs could benefit from DBT skills

Skills modules in DBT

- Mindfulness
- Emotion Regulation inc PLEASE skills
- Distress Tolerance
- Interpersonal

Increasing application of mindfulness-based therapies

ED behaviours as emotion regulation or interpersonal strategies

- Emotional dysregulation often evident in bulimic disorders
- Dysregulated emotional states are a major trigger for bulimic behaviours
- Truncating of emotions can be a maintaining factor
- EDs can have an interpersonal function e.g. eliciting care, esp. if interpersonal skill deficits (extrapolating from IPT evidence)

So likely absence of more adaptive skills in both domains

? skills training alone (partial DBT)

One uncontrolled pilot suggests this can be of benefit:

Evaluation of DBT Emotional Coping Skills Groups for People with Parasuicidal Behaviours Sambrook, Abba & Chadwick. Behavioural and Cognitive Psychotherapy, 2006, 35, 241–244

Need to carefully assess & select cases

- Patients need to have multiple target behaviours but be able to participate in skills learning without individual therapy
- Approx 50% of partial DBT recipients in Portsmouth are eating disordered
- Drop out problems but those who stick benefit

More research of dismantled/ partial DBT needed

Applying DBT skills when treating EDs

The treatment of AN has a number of parallels to DBT

- Change is usually extremely challenging for the patient
- Change is slow and arduous at times for both client and therapist
- Addressing change can present challenges to the relationship between therapist and patient
- Effective therapy requires focusing on specific behavioural change (as recommended in the NICE guideline for eating disorders) whilst also demonstrating profound acceptance for the client.

Relevant DBT strategies

- Commitment strategies
- Validation
- Dialectics and dialectical strategies
- Irreverence

Commitment strategies

- Selling commitment : evaluating pros and cons (do pros first/ evaluate meaning not numbers).
- Playing devil's advocate
- Foot-in-door and door-in-face techniques
- Connecting present commitment to prior commitments
- Highlighting freedom to choose and absence of alternatives
- Shaping – get a bit, be reinforcing, get a bit more

Role play a commitment session

Patient stating

- she cant gain weight
- she doesn’t think she can continue with therapy because of her university timetable
- she cant continue in a group because of her anxiety
- she hasn’t kept a food diary

VALIDATION-what is it?

Patient's responses make sense and are understandable in context i.e. within the client's current life situation

Search for, recognise, reflect the validity in her response to events

Validate client's inherent ability

- Assume the best. Provide encouragement
- Focus on capabilities: belief in patient & treatment

6 levels of validation

1. Staying Awake: Unbiased Listening & observing
2. Accurate reflection
3. **Articulating the un-verbalised emotions, thoughts or behaviour patterns**
4. **Validation in terms of past learning** or biological dysfunction.
5. **Validation in terms of present context or normative functioning**
6. **Radical Genuineness**

Examples of each

Dialectics

Investigating and synthesizing apparently opposing or contradictory ideas.

In a dialectical world view, change is considered a continuous and essential part of life. In therapy, both the client and the therapy itself are in a state of transformation.

Dialectics & the nature of reality

1) every thing is connected to everything else;

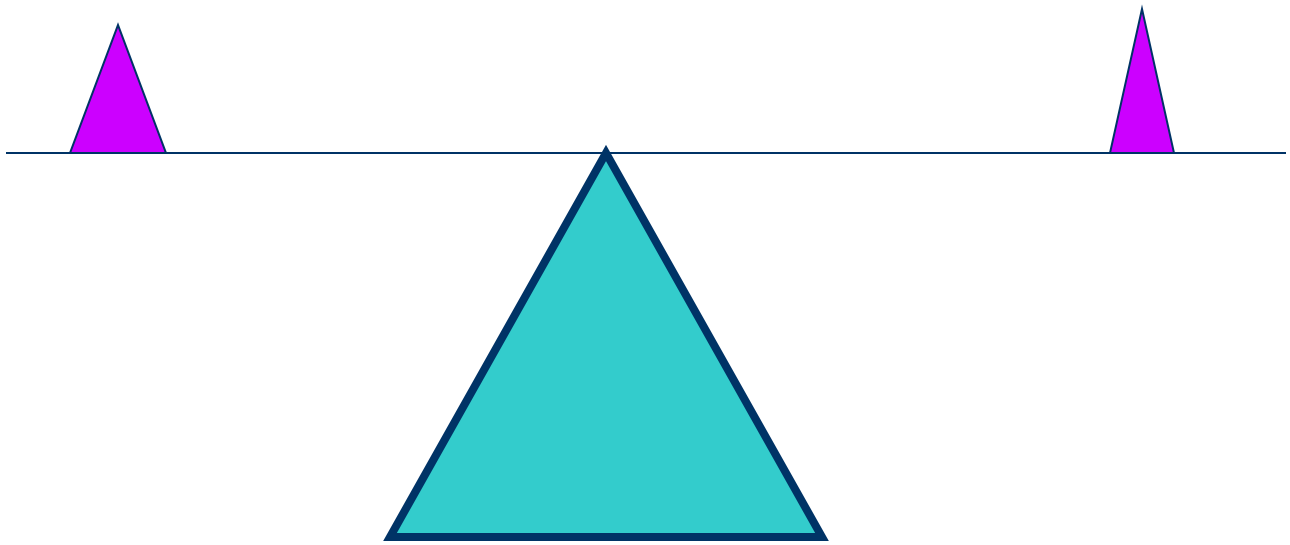
2) change is constant and inevitable; and

3) opposites can be integrated to form a closer approximation to the truth (which is always evolving).

Dialectics are very apparent in EDs

Such as the dialectic between change and acceptance. For example, therapists will need to recognise and validate how the patient is trying her hardest and also ask that she has to try harder.

Acceptance & change:



Another relevant dialectic…….

nurturing

vs

benevolent demanding

Can you think of any others?

Discuss in 2s and 3s

Motivational engagement stance

vs

Don’t work harder than the patient

Challenging patients beyond their comfort zone

Developing staff-patient attachment

vs

Promoting autonomy and independence

Collaboration

vs

Authority

(AN) change is slow

vs

Setting limits to treatment length

Offering treatment contingent on effort and change

Graph of relative effort of therapist and patient

Dialectical strategies

1 Entering the paradox

- Refuse to step in with logical explanation to allow the client to step out of the struggle
- 'Both-and' not 'either-or'

Egs in ED **On the one hand**…….

- Weight gain???
- Admission???

Dialectical strategies

2 Using metaphor

- Stories are easier to remember
- Metaphors can communicate difficult stuff - e.g. the effect of client's behaviour on others
- **What metaphors do you use in treatment?**

Dialectical strategies

3 Devil's advocate

e.g. Given your history, I'm not sure you can restore your weight or

Are you sure you want to? It's going to be very hard work.

Client presents antithesis

'But this time……'

Dialectical strategies

4 Extending

- Take the patient more seriously than she takes herself
- Take anticipated consequences literally then respond to seriousness

E.g. ‘I see, you really can’t carry on with therapy, shall we consider ending?’

Dialectical strategies

5 Activating wise mind

- ‘What do you know in your wise mind to be true/right?’

When would you use this in EDs?

Dialectical strategies

6 Making lemonade out of lemons

- ‘I cant bear to be weighed

‘what a wonderful chance to practise distress tolerance’

- ‘It was so difficult to eat that’

‘good, now we know you can do hard things’

Dialectical strategies

7 Allowing natural change

- Change development and inconsistency are inherent in any environment and are allowed to proceed naturally
- The client is encouraged to learn to tolerate and adapt to change rather than keep environment stable

Egs in EDs???

e.gs

- E.g. tolerating limited food choices (no ham – aaaaaaaaaaarrrrrh!)
- Different therapists
- Deviating from menu plan in a patient with rigidity
- Tolerating weight fluctuation

Irreverent style:

1 reframing (in unorthodox manner)

- E.g. ‘so, what you’re saying is that you’d rather suffer from AN for the rest of your life than do this hard thing?

2 where angels fear to tread

- E.g. ‘I’m sorry, we just have no success with corpses’

3 confrontational tone

- E.g. so what have we been doing all these months?

Irreverent style (contd)

4 calling patient's bluff

E.g. 'OK so I am no good as a therapist, perhaps you should sack me?'

5 Intensity and silence

E.g. look long at client and say nothing

6 omnipotence and impotence

E.g. 'tell us what you want to eat and we'll get it'

'They didn't have that brand so we had no choice'

Irreverence

- When may it be appropriate?
- When to avoid

Discussion

Is DBT available in my area?

If not how might we develop a DBT service?

How can DBT inform my practise as an ED therapist?

References

Linehan et al 1993 CBT of BPD New York Guilford Press

Linehan et al 1993 Skills training Manual for treating BPD New York Guilford Press

Wiser, S. & Telch, C. F. (1999) Dialectical behavior therapy for binge-eating disorder. *Journal of Clinical Psychology*, **55**, 755–768.

Wisniewski, and Kelly. The application of dialectical behavior therapy to the treatment of eating disorders. Cognitive and Behavioral Practice Volume 10, Issue 2, 2003. pp131-8

Wisniewski & Ben-Porath. Telephone skill-coaching with eating-disordered clients: clinical guidelines using a DBT framework. European Eating Disorders Review, Volume 13, Number 5, September 2005, pp. 344-350(7)

DBT & Eating disorders chapter 7 in DBT. Dialectical Behavior Therapy in Clinical Practice: Koerner & Dimeff 2007

The Dialectical Behavior Therapy Skills Workbook for Bulimia: Using DBT to Break the Cycle and Regain Control of Your Life Astrachan-Fletcher & Maslar 2009

Dialectical Behavior Therapy for Binge Eating and Bulimia Safer et al 2009

Kristeller, J. L., & Hallett, C.B. (1999). An exploratory study of meditation-based intervention for binge eating disorder. *Journal of Health Psychology*, 4, 357–363.

Levine, M. & Marcus, M. (2003). Psychosocial Treatments of Binge Eating Disorder: An Update. Article in *Eating Disorders Review.* July/August Vol. 14/NO.4

McCabe EB, La Via MC, Marcus MD. Dialectical behavior therapy for eating disorders. In JK Thompson, ed. Handbook of Eating Disorders and Obesity. New York: John Wiley & Sons, Inc., in press.

Palmer RL, Birchall H, Damani S, Gatward N, McGrain L, Parker L. (2003). A dialectical behavior therapy program for people with an eating disorder and borderline personality disorder-description and outcome. Int J Eat Disord. 33(3):281-6.

Safer DL, Telch CF, Agras WS. (2001). Dialectical behavior therapy for bulimia nervosa. Am J Psychiatry. Apr;158(4):632-4.

Safer DL, Telch CF, Agras WS (2001). Dialectical behavior therapy for bulimia nervosa: a case study. Int J Eat Disord; 30:101-106.

Telch CF: Skills training treatment for adaptive affect regulation in a woman with binge-eating disorder. Int J Eat Disord 1997a; 22:77-81.

Telch CF: Emotion Regulation Skills Training Treatment for Binge Eating Disorder: Therapist Manual. 1997b. Unpublished manuscript

Telch CF, Agras WS, Linehan MM: Group Dialectical Behavior Therapy for binge-eating disorder: A preliminary, uncontrolled trial. Behavior Therapy 2000; 31:569-582.

Telch CF, Agras WS, Linehan MM: Dialectical Behavior Therapy for Binge Eating Disorder. J Consult Clin Psychol 2001; 69: 1061-1065. Wiser S, Telch C (1999): Dialectical behavior therapy for binge-eating disorder. J Clin Psychol 1999; 55:755 - 768.

Wisniewski, L, & KellyE. (2003). Can DBT be used to effectively treat eating disorders? Cognitive and Behavioral Practice, 10, 131-138.